PERCEIVED MORBIDITY, HEALTH SEEKING BEHAVIOUR AND HEALTH CARE UTILISATION AMONG INTER-STATE WOMEN MIGRANT WORKERS IN KERALA

Synopsis submitted to CHRIST (Deemed to be University)
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IN

SOCIAL WORK

by

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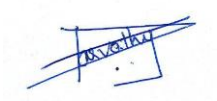

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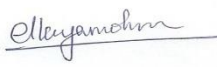
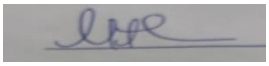
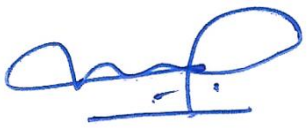
Approved by: 1. Name of Supervisor: Hemalatha K 2. Name of RAC Member: Maya M 3. Name of RAC Member: Mathew P M 4. Name of External reviewer if applicable	Signature  

Head of Department: Dr Victor Paul: 

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ABSTRACT

Internal migrants in India is estimated to be 37% of the total population with Kerala estimated to host over 25 lakh, internal migrants.Migration, both internal and international can influence a country or region's socio-economic development. The interrelation between health and migration is highlighted in the Sustainable development goals where health is determined as an indicator of "people-centred, rights-based, inclusive, and equitable development" (UN, 2015).Though migrants as such are a vulnerable population, the Gender experience of migration differs, as women migrants often face triple discrimination of being a woman, unprotected worker and a migrant making them the most vulnerable within the migrant community. They are often overlooked while formulating schemes and policies depriving them of health and social security benefits. The present study aims to understand the perceived morbidity, health-seeking behaviour and healthcare utilisation among Interstate Women Migrant Workers in Kerala. The sequential exploratory research design was employed to collect data from workers in the seafood processing and textile manufacturing sector. The qualitative phase had two focus group discussions with 8 participants each and four in-depth interviews while the quantitative phase had cross-sectional surveys with 300 respondents. The focus group discussion and in-depth interview paved way for understanding the issues and concerns of the respondent's regarding their health-seeking behaviour and health care utilization as well as hinted at their attitude towards health in general. Themes were able to provide insight into the factors underlying healthcare utilization as well as provided suggestions from the respondents which could have policy implications. The quantitative data was elaborate and was able to address the various dimensions of health-seeking and determine the factors influencing healthcare utilization among interstate women migrants in Kerala. Inferential statistics also revealed a significant relationship among Health Status with Health Seeking

Behaviour(p=.042) and with Health care utilization (p=.023) while Health care utilization with Perceived morbidity (p=.000) and with Health Status (p=.007). The sector-wise differences were also noted with the seafood processing sector showed higher healthcare service utilization (57.6%) than the textile manufacturing sector (42.4%). The binary regression carried out among14 independent variables reported 10 independent variables making a statistically significant contribution to the model with the highest being Health Insurance 2.998 [95.0% C.I: 1.481- 5.287] and Educational Qualification 2.979 [95.0% C.I: 1.294 - 6.62].The study finds its relevance in providing agender centric lens to exploring women migrant worker's health profile, health-seeking behaviour, the challenges and barrier in availing health services and the changes that need to be adopted for improving healthcare facilities thereby improving their health and wellbeing and prevent a threat to public health and wellbeing. The study has both research and policy implications.

Keywords: *Women Migrants, Interstate migrant workers, Healthcare utilization, perceived morbidity, Health seeking behaviour*

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Introduction

Background

Migration has become a social, economic and universal phenomenon and is considered to be multi-dimensional in modern times. Migration, both internal and international can influence a country or region's socio-economic development such as its population size, age structure and labour market. It can be seen as a result of the social, economic and regional imbalances among countries. It has resulted in a worldwide process of urbanization and industrialization leading to an increasing gap between rural and urban areas thus causing the collapse of rural livelihood in many parts of the world. The global pattern of migratory movement is determined by various factors such as poverty, demographics, natural calamities, better economic opportunities, political chaos and other numerous socio-economic and cultural changes. Human Development Report 2016 have reported, the international migrant population to be at 214 million people which is about 3% of the world population whereas the internal migrant population to be at 740 million. Urbanisation is one of the major factors for the increase in migrants. Internal migration where one does not cross any national border is referred to as the largest migration in the world. Migration is a social phenomenon that is influenced by both underdevelopment as well as development. Data from the 2011 census indicate that the states with lower levels of development like Uttar Pradesh, Bihar, and Orissa have witnessed higher volume and rate of female out-migration whereas states with higher levels of development like Maharashtra and Delhi have received more in-migration.

Health is an important concern for migrant workers as most of the countries have formulated Nationalised health schemes based on the place of residence which prevents migrants from access to these health services. Sustainable Development Agenda, considers health both as a beneficiary and a contributor, it is central to the social, economic and environmental dimensions of SDGs. The interrelation between health and migration is highlighted in the Sustainable development goals where health is determined as an indicator of "people-centred, rights-based, inclusive, and equitable development" (UN, 2015).India has an estimated 740 million internal migrants which are found to be three times higher than the International migrants in India estimated at 214 million (UNDP,2009). The Census of India reported the increase in internal migration from 315 million in 2001 to 400 million in 2011. The internal migrants though

are guaranteed the basic constitutional rights irrespective of the caste, religion, domicile state or language, they seldom benefit from these rights. Right to Right to basic health constitution right provided by the Indian government to all its citizens. It holds the respective states responsible for ensuring good quality and transparent health care services to all its population including the migrant worker. Yet these are provisions that migrants can only dream of, the language barriers, work hours, proper registration and unawareness of the health provisions provided by the government prevents them from accessing health care services making them vulnerable to health issues (Kumar. N, 2011). The Indian state of Kerala had witnessed an influx of migrant workers in the past decade. In the year 2013, the Gulati Institute of Finance and Taxation conducted a study on behalf of the Department of Labour and Rehabilitation, Government of Kerala on internal migrants. The survey estimated that Kerala receives over 2.35 lakhs of migrants every yet and that the current estimate of inter-state migrants who were currently employed in different districts across the state were over 25 lakhs who make up of remittances of about Rs. 17,500 crores to their home states annually. As of 2017, it was estimated that number of inter-state migrants would increase to 40 lakhs. Kerala is witnessing a replacement migration due to the lack of workers available to take up 3D (dirty, dangerous and demanding) jobs. In India, Since 2013 National Urban health mission (now National Health Mission) was placed with the responsibility of proving health-related services to the migrant population yet their activities are found to be very limited. These bodies need to scale up their programme to reach a wider migrant population. In Kerala, the National health mission has recognised the need for a health wing exclusively for the migrant population. Yet very little attention has been paid to the health issues of migrant women workers. Though these workers are provided provisions similar to the local population, there is a lack of awareness and underutilization of health services by these women workers in Kerala.

Need and Significance of the Study

Migration isa global phenomenon that concerns countries and people all across the globe. It can be considered a multidimensional phenomenon with its roots in the economic, political, social and public health dimensions. India at large has been experiencing internal migration and was found to have an estimate of 45.36 crore that is about 37% as per the census of 2011. This rate is only going to increase in the coming years with millions crossing regional territories. Kerala is reported to have a large influx of migrant population in the coming years making it vulnerable to many other issues

that are accompanied with the process of migration. Migration affects men and women differently even though the migration rates among men and women are found to be similar. The triple discrimination faced by migrant women workers, first as women, second as unprotected workers, and lastly as migrants makes them the most vulnerable within the migrant community. This vulnerability causes marginalization in terms of labour market participation as well as participation in society in general. Even though there are studies available on health-seeking behaviour concerning both urban and non-urban regions, the same cannot be said for studies concerning health care issues of migrant workers especially female migrant labourers. The health of the women migrants is influenced by many intersecting factors such as physical, economic and social well-being along with the discriminatory practices linked to Ethnicity, race and poverty. women's roles in society are often defied by social and gender norms, adding to which is the Traditional values and beliefs altogether which impacts access to healthcare information and services. Migrant women have the need and right to access health care yet due to their migration status they are systematically excluded from health systems. Studies on migrant's health are found to be very less in a state where there is an alarming need to focus on migrants. Studies are even lesser on the health of female migrant labourers while available studies on women migrants had paid very little attention to the health-seeking behaviours or their access to health care utilization. Most of the Studies conducted were focused on specific health issues such as AIDS, tuberculosis or regarding their reproductive health. Female migrants are often ignored when formulating migrant policies and gender sensitivity is not maintained. The primary reason for this is the assumption that women migrate as dependents and not as economic players which diminishes their chance to be represented and addressed by government policies. This strips women migrants, from being protected by the same safety net which is readily available for male migrants. therefore the need for studies to take up a gender-specific lens to explore the health of female migrants and to help address the health concerns which can eventually be integrated into state migrant health policies. The health status of the concerned state can be highly influenced if the health issues of their migrants are not given the needed significance. Hence, the need for studies to move beyond to overall health profile of female migrant workers, with this objective the study finds its relevance in Providing gender centric lens to exploring women migrant worker's health profile, health-seeking behaviour, the challenges and barrier in availing health services and the changes that need to be adopted for improving health care

facilities thereby reducing the threat of a public health outbreak as well as to improve the public health and wellbeing.

Review Of Literature

The review was carried out in the studies in the field of women migration concerning Perceived Morbidity, Health Seeking and Healthcare Utilization as well as a Theoretical and Conceptual Framework is also provided. The review has also yield discussions on the barriers, challenges and factors influencing health-seeking and Healthcare Utilization among migrants. The studies have been reviewed and placed under seven major themes. The themes are as follows,

- Internal Migration and Health
- Women And Migration
- Women Migrants And Health
- Magnitude Of The Issue
  - Migration And Health In International Context
  - Migration And Health In National Context
  - Migration and Health in Kerala context
- Migration And Perceived Morbidity
- Migration And Health Seeking Behaviour
  - Literacy And Health Seeking
- Migration And Health Care Utilisation
  - Health Insurance Coverage And Health Care Utilisation

Research gap

Women and migration is a well-explored topic in the international context. Health dimensions in the context of women migrant workers are given utmost significance at the global, national and regional levels. At the international level, there are literature focussing on the health-seeking and health care utilization of migrant workers along with its connection to other sociodemographic variables. At the national level, the studies have focussed more on understanding the socioeconomic challenges and

discrimination faced by women migrant workers. Though the focus should be holistic, very few studies have concentrated on the health-seeking and healthcare utilization patterns of women migrants. And even within the studies focusing on these variables, it can be noted that attention is given more to maternal and reproductive health care utilization than health in general. The women migrants are still invisible to the larger public domain and their health needs are mostly reduced to reproductive needs. Some studies focus on discrimination and exploitation of women migrant workers yet little address is given to the health disparity faced by them. In the context of Kerala, studies on migration have largely been based on male migrants, very little attention is given to women migrants. studies that explore the health concerns of women migrant workers are limited to certain work sectors such as construction and plywood. Women migrant due to their scattered presence in the state makes it difficult for studies to explore their issue concerning health. There are very few studies on the health-seeking and health care utilization patterns of women migrants in Kerala. The studies that explore the relationship between migration and public health is found to be limited in the Kerala context. Therefore the need for female migrants' specific studies, which will focus on understanding their health and ways to address these health concerns, explore the health-seeking behaviour and health care utilization pattern and its relation to public health. All this together expands the scope of the current research study.

Research Questions

1. Does the interstate women migrant report morbidity? If so, how is their Health Seeking Behaviour and how does it influence the Healthcare Utilization
2. Is there a relation between Perceived Morbidity, Health Seeking and Healthcare Utilization of Interstate Women Migrants in Kerala?
3. Is there a difference in Perceived Morbidity, Health Seeking and Healthcare Utilization among Interstate Women Migrants working in different sectors of employment?
4. Is there a difference in Health Seeking Behaviour and Healthcare Utilization attributed to personal and job-related factors?
5. What are the factors that determine Healthcare Utilisation among Interstate Women Migrants in Kerala?

Methodology

Aim

To Study the Perceived Morbidity, Health Seeking Behaviour and Healthcare Utilisation among Interstate Women Migrant Workers in Kerala

Operational Definitions

Interstate Migration: Interstate Migration refers to those semi-skilled people belonging to low socioeconomic status who have moved from all states of India to Kerala in search of job opportunities.

Interstate Migrant Women Worker: Interstate Migrant women workers refer to those semi-skilled women workers belonging to low socioeconomic status who have migrated from all states to Kerala and are working in Kerala for the last six months or above.

Health seeking behaviour: It refers to the behaviours that signify accessing Healthcare services during health issues. This includes the individual factors, marketing factors, situational factors, previous experience with utilizing health services and psychological factors that influence the Health Seeking behaviour.

Perceived Morbidity: It refers to the self-reported health issues either prevalent before the arrival to Kerala and the incident of health issues after the arrival in Kerala

Healthcare Utilization: The frequency of visit, seeking diagnosis and treatment for perceived ill-health challenges or barriers to effective utilization, commutation to the Healthcare facility

Variables of the Study

The variables of the study were**,**

Dependent variable

- Healthcare Utilization
- Health seeking behaviour

Independent variable

- Perceived morbidity
- Heath status

- Personal Variables: Age (In Years), Marital Status, Educational Qualification
- Job-related variables: Sector, Income, Working Hour Per Day, Work Days Per Month, Duration of Stay
- Migration related variables: Place of Birth, State, District

Research Design

The present study has made use of Mixed Methods Research Design. Within mixed methods, The study has made use of a Sequential Exploratory study design. The qualitative phase made use of focus group discussion and in-depth interview as a mode of inquiry while the quantitative phase made use of a cross-sectional survey.

Phase 1- Qualitative

Objectives

1. To Explore the existing Healthcare needs of the Interstate women migrant workers
2. To Explore the challenges and barriers that reduce effective Healthcare utilization

Study setting

Due to the unavailability of comprehensive data regarding the location of the women migrants in different districts, the study focussed on collecting data from two districts in Kerala being Trivandrum and Ernakulam as they are having a higher number of migrant pockets. Within these districts, The major sectors where women migrants reemployed were identified to be textile manufacturing in Trivandrum district and seafood processing industries in Ernakulam district. The sector identification was followed by the identification of the company where these women are employed to get the sample frame for the study. Purposive sampling was used to select the companies to obtain permission for data collection. Accordingly, 3 companies 2 from Ernakulam and 1 from Trivandrum were selected for data collection with restrictions. Due to the high confidentiality clause, the names of the companies cannot be revealed.

Sampling

- **Study Population**: Inter-state women migrant workers working in selected industries of the seafood processing industries and textile manufacturing sector in Ernakulam and Trivandrum district of Kerala respectively.
- **Sample:** For the Qualitative phase, two Focus group discussions were held with each having 8 interstate migrant women workers from the seafood processing industry in Ernakulam and textile manufacturing industry in Trivandrum. For the in-depth interview, 2 interstate migrant women workers each from a seafood processing industry in Ernakulam and textile manufacturing industry in Trivandrum were selected.
- **Method of sampling**: The Qualitative phase made use of Non-probability sampling where snowball sampling under non-probability sampling was employed to get appropriate data.
- **Sample selection criteria**

  The criteria used for selecting the sample for In-depth interviews were women who have been working in Kerala for the last 6 months and had experienced or currently experiencing a health issue after migration to Kerala and have visited health facilities at least once. For the Focus Group Discussion, the participants who have been working in Kerala for the last 6 months and had experienced or currently experiencing a health issue after migration to Kerala for the past 6 months. The rationale behind using two different criteria was to ensure the participants selected for the In-depth interview were able to provide information on their previous experience of healthcare utilization as well as to assess the quality of the health services availed.

Tools of data collection

1. **Focus Group Discussion Guide**

   The Focus Group Discussion Guideways formulated to understand the health and healthcare needs and utilization by inter-state female migrants in Kerala. The discussion is planned to cover questions to understand the experiences of the migrant workers while seeking Healthcare as well as their existing Health Seeking behaviour. The question would also focus on obtaining information on migrant workers' understanding of the local Healthcare system including, but not limited to, concepts such as health insurance (AWAZ), primary health centre and migrant help centre.

2. In-depth Interview Guide

The In-depth Interview schedule was formulated to understand individual experiences while seeking information about health or social services, trying to access Healthcare services or obtain health insurance coverage.

Validity of the tool

The present study has used content validity as a measure of validity. For this purpose, it was submitted to 5 experts. The five field experts were The Research head of the Kerala Institute of Labour and Employment, Trivandrum; Professor of the Centre For Development Studies, Trivandrum; Head Of Community Health Department of the Medical College, Trivandrum, Head of Public Health Department of the Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum and the centre head of the Kerala Interstate Migrants Alliance for Transformation, Trivandrum. The suggested modifications were made to the tools.

Analysis of Data

The data was transcribed in Hindi and translated to English with the help of a language expert. Following the translation, the qualitative data was analysed to create codes that were further formulated into relevant themes which was externally validated by two other researchers to prevent bias. For Qualitative Data Analysis, first, the Focus Group Discussion transcripts were analysed following the six steps suggested by Krueger(1998). During the analysis, 46 codes were formulated which were then categorized into various sub-themes and finally placed under 4 major themes. For the analysis of in-depth interviews, the data were transcribed, coded and categorized into various themes following the six phases of thematic analysis prescribed by Braun and Clarke (2006). The initial analysis revealed 25 codes which were then formulated to five major themes. Finally, the themes formulated from Focus Group Discussion and In-Depth Interviews were compared to find the similarities and differences to integrate the data collected. The similar themes were clubbed together while unique themes were placed separately. Subsequently arriving at 16 subthemes placed under 7 major themes.

Phase 2 - Quantitative

Objectives

1. To study the socio-economic background of the interstate women migrant workers
2. To analyse the living conditions and working conditions of the Interstate women migrant workers
3. To study the self-reported health morbidity pattern of the Interstate women migrant workers
4. To study the health risk behaviour of the Interstate migrant workers
5. To study the dimensions associated with the Health Seeking Behaviour among the Interstate women migrant workers
6. To understand the existing Healthcare utilization by the Interstate women migrant workers
7. To study the difference in perceived morbidity, Health Seeking Behaviour and Healthcare Utilization among interstate women migrants across different sectors

Hypotheses

Relation Between Perceived Morbidity, Health Seeking Behaviour and Healthcare Utilization

H 1: There is a Significant correlation between Health Status and Health Seeking Behaviour

H 2: There is a Significant correlation between Perceived Morbidity and Health Seeking behaviour

H 3: There is a Significant correlation between Health Status and Health care utilization

H 4: There is a Significant correlation between Perceived Morbidity and Healthcare utilization

H 5: There is a Significant correlation between Health Seeking Behaviour and Healthcare utilization

The difference in Perceived Morbidity, Health Seeking Behaviour and Healthcare Utilization among different Job Sectors

H 6.1.1: There is a significant difference in Physical Health status across the two Job sectors where women workers are employed

H 6.1.2: There is a significant difference in Mental Health Status across the two Job sectors where women workers are employed

H 6.2: There is a Significant association between Perceived Morbidity and the two Job sectors where women workers are employed

H 6.3 There is a significant difference in health-seeking behaviour across the two Job sectors where women workers are employed

H 6.4: There is a Significant Association between Health Care Utilization and the two Job sectors where women workers are employed

The difference in Health Seeking Behaviour among Personal and Job Variables

H 7.1: There is a significant difference in health-seeking behaviour across Respondent's Age

H 7.2: There is a significant difference in health-seeking behaviour across Respondent's Marital Status

H 7.3: There is a significant difference in health-seeking behaviour across Respondent's Place of Residence.

H 7.4: There is a significant difference in health-seeking behaviour across Work Hour

H 7.5: There is a significant difference in Health Seeking Behaviour across Respondent's State of Migration

H 7.6: There is a significant difference in health-seeking behaviour across Respondent's Educational qualifications

H 7.7: There is a significant difference in health-seeking behaviour across Respondent's Income

H 7.8: There is a significant difference in health-seeking behaviour across Respondent's Workdays

H 7.9: There is a significant difference in health-seeking behaviour across Respondent's Duration of stay

The difference in Health Seeking Behaviour and Healthcare Utilization among Personal and Job Variables

H 8.1: There is a Significant Association between Respondent's Age and Health Care Utilization

H 8.2: There is a Significant Association between Marital Status and Health Care Utilization

H 8.3: There is a Significant Association between Place of Residence and Health Care Utilization

H 8.4: There is a Significant Association between work hour and Health Care Utilization

H 8.5: There is a Significant Association between Respondent's Income and Health Care Utilization

H 8.6: There is a Significant Association between Respondent's Educational Qualification and Health Care Utilization

H 8.7: There is a Significant Association between Respondent's State of Migration and Health Care Utilization

H 8.8: There is a Significant Association between workdays and Health Care Utilization

H 8.9: There is a Significant Association between Duration of Stay and Health Care Utilization

Sampling design

- **Sample**: For the quantitative Phase, 300 interstate migrant women workers are selected for the study, of which 150 interstate migrant workers are selected from the textile sector in Trivandrum district and 150 interstate migrant workers are selected from the seafood sector in Ernakulam district abiding the inclusion and exclusion criteria. The participant selected for the Qualitative phases were excluded in the Quantitative phase to better include more samples for the study.
- **Method of sampling**: systematic sampling under probability sampling was used to collect the data from 300 interstate women migrant workers employed in textile manufacturing and seafood processing industry in Trivandrum and Ernakulum district of Kerala respectively. The list of the employees was sought from HR which was then followed by listing them by numbers. The total number of employees were 386 in the seafood processing industry and 539 in the textile manufacturing industry. The N value for the systematic sampling was calculated using the formula N=

$\frac{Total\ Population}{Total\ Sample\ Size}$. Accordingly, every N^{th} employee (N=2 for seafood processing and N=3 for textile manufacturing) in the respective list were approached for the data collection.

❖ **Inclusion criteria:**

- Individuals working in the seafood processing industry in Ernakulam and textile manufacturing industry in Trivandrum district of Kerala for a continuous six months or above from any one of the Indian states of India to Kerala

Tools of data collection

For the quantitative data, the following tools were used:

Section A: Personal and Socio-demographical information

Section B: Self-reported morbidity pattern

- Health survey short form (SF-12) by John E. Ware, Jr.
- Health issue checklist by AbdulbariBener (2017), Sreejini J (2012) and Suneela Garg, Meenakshi, M.M.C. SinghandMaltiMehra (2001).

Section C: Health seeking behaviours

- Illness Behavior Inventory (IBI)by Ira Daniel Turkat and Loyd S. Pettegrew
- Treatment seeking behaviour survey by Mohammad Amin Bahrami, OmolbaninAtashbaha, Marzieh Shokohifar and RaziehMontazeralfaraj

Section D: Health Care Utilization

- The pattern of Healthcare Utilization and Health Insuranceby Ang JW, Chia C, Koh CJ, et al. (2017), Fang, et al. (2014) and Sreejini J (2012).
- Patient Perceptions of Health Care Quality by Krishna Dipankar Rao, David H. Peters and Karen Bandeen-Roche

Pre-test

The tools were Pre-tested among 20 respondents to calculate the reliability of the tools used. Based on the analysis of the participant responses obtained in the pre-test, it was inferred that there is a need for questions specifically addressing health insurance and the barriers and challenges to Healthcareutilization.Therefore 3 questions related to health insurance and 1 question related to challenges and barriers in Healthcare

utilization were added. The tools were also tested for reliability using Cronbach's alpha coefficient.

Reliability of the tools

Table 1 shows the reliability of each of the scales used in this study using Cronbach's alpha coefficient. All the scales were found to have good internal consistency and high reliability as they have scored a Cronbach's alpha coefficient value of above .7.

Table 1

Reliability of Scales

Scale name	Number of items	Indicator of internal consistency	Value
Health survey short form (SF-12)	12	Cronbach's alpha coefficient	.855 (PCS) .846 (MCS)
Illness Behavior Inventory (IBI)	20	Cronbach's alpha coefficient	.754
Treatment seeking behaviour survey	47	Cronbach's alpha coefficient	.765
Patient Perceptions of Health Care Quality	16	Cronbach's alpha coefficient	.776

Analysis of Data

The Quantitative Data Analysis was carried out using the IBM Statistical Package for Social Science (SPSS 25.0). The data were first tested for normality using the Shapiro-Wilk test which revealed that the data was not normally distributed. This led to the use of a Non-Parametric test for the data analysis.

Data Integration

The triangulation of the data obtained has helped in enhancing the findings as well as helped in providing a clearer understanding of the problem. The research study has

made use of Methodological triangulation (Denzin, 2006) to integrate the data obtained through qualitative and quantitative methods. The triangulation has taken place during data analysis where qualitative data through exploration paved a framework for quantitative analysis as well in explaining the findings of the quantitative phase. The triangulation has helped to validate the data sources as well as provide develop a comprehensive understanding of the perceived morbidity reported, Health Seeking Behaviour and health utilization pattern among interstate women migrant workers in Kerala.

Ethical Considerations

The Ethical Clearance for the study was carried out by the Centre for Research, Christ Deemed to be University. The Reacher has undertaken various steps to ensure the data was collected abiding the ethical considerations.

Results and Findings

The results and findings are discussed under the following headings,

PART A: Qualitative

I. **Participant Profile of the Focus Group Discussion and In-Depth Interview plural**

II. **Discussion of the Focus Group Discussion and In-Depth Interview plural**

PART B: Quantitative

I. **Profile of the Respondents**
   1. Personal profile
   2. Job profile
   3. Migration profile
   4. Working and Living Conditions
   5. Adverse Health Behaviour

II. **Perceived Morbidity and Health Status of the Respondent**
   1. Health Status of the Respondents
   2. Self-Reported Morbidity and Severity
   3. Self-reported Health Issues and Symptoms

III. **Health Seeking Behaviour of the Respondents**
   1. Overall Health Seeking Behaviour among the Respondents

2. Dimensions of Health Seeking Behaviour
    a. Actions undertaken during the illness
    b. Health care providers from health care consumers' viewpoints
        i. Patients Previous Experience of Services Consuming
        ii. Consumers Evaluation from Health Care Providers
    c. Psychological Factors
    d. Individual Factors
    e. Socio-Cultural and Familial Factors
    f. Situational Factors
    g. Marketing Factors

IV. Health Care Utilization of the Respondents

1. Previous Hospitalization details of the respondents
2. Barriers to Utilization of Health Services
3. Health Insurance
4. Satisfaction and Quality of Health Care Services

V. The Relation between Perceived Morbidity, Health Seeking Behaviour and Healthcare utilization

1. Relation between Perceived Morbidity, Health Status and Health Seeking Behaviour
2. Relation between Perceived Morbidity, Health Status and Healthcare utilization
3. Relation between Health Seeking Behaviour and Healthcare utilization

VI. Testing for the difference in Perceived Morbidity, Health Seeking Behaviour and Healthcare utilization among different sectors

1. Testing for the differences in Perceived Morbidity among different sectors
2. Testing for the difference in Health Seeking Behaviour among different sectors
3. Testing for the difference in Healthcare utilization among different sectors

VII. Testing for the difference in Health Seeking Behaviour and Healthcare utilization among Personal Variables and Job Variables

1. Testing for the difference in Healthcare utilization among Personal Variables and Job Variables

2. Testing for the difference in Healthcare utilization among Personal Variables and Job Variables

VIII. Factors Influencing Health Utilization among Respondents

4.1 Results and discussions

PART- A Qualitative Phase

Figure 1 shows the sub-themes formulated as part of the thematic analysis of the focus group discussion and in-depth interview. Table 2 portrays the Major themes along with their corresponding subthemes identified.

Figure 1

Overview of the sub-themes

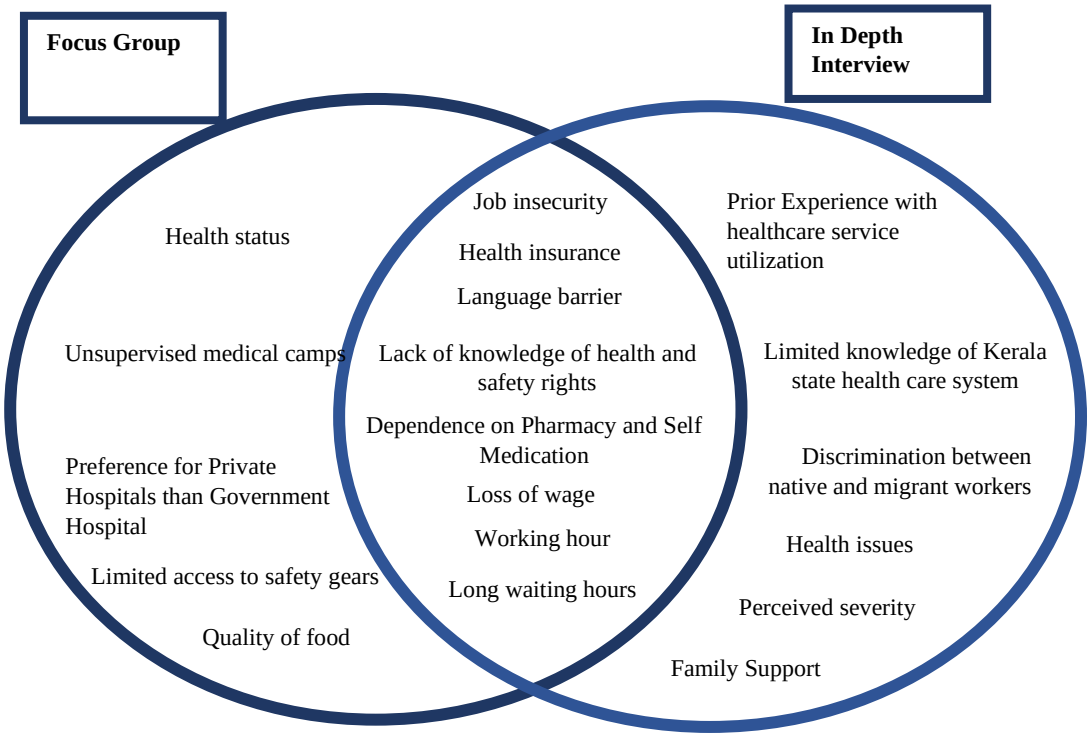

Table 2

Overview of the Themes and their Corresponding Subthemes

Major themes	**Common subthemes**	**Focus group discussion specific subthemes**	**In-depth interview specific subthemes**
Theme 1 Health Perception and Health Status	**Sub-theme** 1: Perception about Health	**Sub-theme** 2: Health status	**Sub-theme** 3: Health issues
Theme 2 Factor affecting Health Seeking Behaviour	**Sub-theme 4**: Loss of Wage **Sub-theme 5**: Lack of Time **Sub-theme 6:** Dependence on Pharmacy and Self Medication		**Sub-theme 7:** Perceived Severity
Theme 3 Factor affecting Healthcare Utilization	**Sub-theme 8:** Language Barrier **Sub-theme 9:** Lack of Money to Pay the Fee for Services **Sub-theme 10**: Health Insurance	**Sub-theme 11:** Preference for Private Clinics to Government Services	**Sub-theme 12:** Family support
Theme 4 Previous experience with healthcare service utilization			**Sub-theme 13:** Behaviour of healthcare providers **Sub-theme 14:** Language and cultural limitations **Subtheme: 15**: Financial constraints **Sub-theme 16**: Long waiting hours

Theme 5 Lack of knowledge of Health and Safety Rights	**Sub-theme 17:**Unawareness of the work rights and benefits	**Sub-theme 18:** Limited access to safety gears **Sub-theme 19:** Unsupervised Medical Camps	
Theme 6 The distinction between Native and Migrant Workers		**Sub-theme 20:** Quality of Food provided	**Sub-theme 21:** Work hours
Theme 7 Limited knowledge of Kerala state Health Care			✔
Theme 8 Suggestion Given by Women on the Health	✔		

The focus group discussion and in-depth interview paved way for understanding the issues and concerns of the respondents about their health-seeking behaviour and health care utilization as well as hinted at their attitude towards health in general. The themes identified the areas that needed attention and necessary intervention. The changes need to be taken not only at the industry level but also at the various government level to ensure these workers are provided with the necessary support. Themes were able to provide insight into the factors underlying health-seeking behaviour and healthcare utilization as well as provided suggestions from the respondents which could have policy implications.

Health was reported not to be a priority that requires special attention, this was especially due to other hardships and issues faced by the migrants. Workers are observed to have low Perceived severity attach to their health issues; this limits their ability to demand immediate access to health services at the onset of a health problem. It is only when an illness became unbearable or untreatable by the patient do the workers find it necessary to seek health care. The health-seeking behaviours were largely influenced by the wage and work hours which forced these workers to resort to self-medication when faced with health issues. The wages for women are low due to

the high supply of migrant workers from various parts of the country (Taran, 2018; Saikia, 2010). They are constantly in fear of being replaced by other migrant workers which pushes them to work even with their illness. Workhours also influences the type of treatment undertaken by them. The average working hours was reported to be 8.5 excluding the lunch. This causes them to reduce their time to visit hospitals in times of a health issue. The worker's preference for private clinics can also be attributed to their workhours (Das &Murmu, 2010; Faetanini, &Tankha, 2013).

The workers stated several barriers to utilization of health care in Kerala such as language, cultural barriers, the fee of services, Preference for private clinics, longer waiting periods and unawareness of the insurance (Le et al., 2015, Taran, 2016; George, 2018; Lu et.al, 2014; Idris et.al, 2017; Lam & Johnston, 2012). Language becomes the biggest challenge for migrant women workers in receiving and utilization of health care in Kerala. Most of the women from the northern and north-eastern parts of the country can understand Hindi and the migrants from the southern part of the country made use of their mother tongue as a medium for communication there for they lacked the needed language skills to communicate their concern to the healthcare providers since almost all of the healthcare providers in the area do not speak or understand Hindi. Most women were confused about the way the doctors explained their problems and issues. Therefore, their trust in these health providers was questionable (Carballo, 2007; Khongthanachayopit&Laohasiriwong, 2017; Gawde et.al, 2016; Babu et al., 2018). Culture is an important barrier that prevents workers from being completely integrated into society. The culture barrier is highly correlated with health and hygiene. The hygiene practices of the migrants are often looked at as derogatory thereby labelling them to be deserving of the health issues and concerns they are currently facing. These same barriers even prevent the workers from opening up to the healthcare providers (Zhong et al., 2018). The behaviour and attitude of the healthcare provider is a very crucial factor in determining the future use of healthcare services. Workers are most of the time not able to express their issues fully and have felt to have been not paying attention to certain aspects of their health concerns. Insurance also plays a very important role in helping migrants seeking health care in times of a health issue (Sreekumar 2019; CMID, 2020; Hoang Lan &Noi, 2011). Though the workers are eligible for both ESI benefits and government health insurance, not many know about either of them or have made use of any. The

employers though give them medical befits by enrolling them in ESI, it is still not properly communicated to the workers. Since they do not have private insurance and are unaware to utilize government-funded insurance, they are forced to pay out of pocket for health services.

Workers reported having very little knowledge of the health care system in Kerala. Most of them were unaware of the health benefits provided by the state exclusively for the migrant population. Kerala has built a strong health system right from the community level to enhance access to health services (Anand, 2017; Krishnakumar, 2012). This is found to be lacking in most of the other states in India. The migrant with their experience of health services at their native place may influence the way they evaluate the service in Kerala as well (Peter &Narendran, 2017). They are observed to be neither having the motivation in approaching health centres for their health issues nor having information regarding the services and free medicines available at the primary health care centres (Evlampidou et al., 2015). Though the Kerala government has launched welfare programs for the interstate workers, very few receive the benefits this is primarily due to the absence of conclusive data regarding the migrants (Peter &Narendran, 2017). There is also no regulative agency to check whether these workers have attained the legal age of working. Though most of the respondents have reported being in the legal age, it was observed otherwise because these age proof could be forged. The helplessness of these respondents to get better pay at their native state as well the ongoing increase in demand for blue-collar workers in Kerala paves ways for discrimination at the highest level (Akinola et.al, 2014; Chandran &Chacko, 2017). Sometimes these workers are even exposed to physical and sexual violence at the workplace which is also supported by various studies on women migrants held across India and globally. These workers are often left with little or no choice to work in a situation with pose a threat to their health and wellbeing. As observed in the qualitative analysis most of the workers did complain about their occupational health issues and how they affected them. These could be avoided if they are provided with safety gear and are given safety instructions. But that alone will not be enough, they also need to be made aware of the work benefits such as the ESI, PF, Gratuity as well as the government schemes available for them. The employers must ensure these workers are registered with the government before offering them a job, this will help in regulating the migration channel and reducing exploitation by mediating agents

(Sreedharan&Murale, 2018). The workers have reported health camps being conducted for them which forces them to undergo mandatory check-ups while not informing them of the results. The workers should be provided with information to the health camps and be given the needed reports as it is their right. Regular awareness classes by health workers as well as migrant welfare workers can aid in increasing their health status, promoting health-seeking and health care utilization. If only when the migrants themselves decide on approaching the needed health facility for their health issue, can we truly eradicate the possibility of a public health threat.

The insights obtained from the qualitative phase helped in framing the variables to be explored in the quantitative phase. The data from the qualitative phase threw light on the focus areas within the larger variables to be explored. The quantitative Phase was framed to be elaborate to be able to address the various dimensions of health-seeking and determine the factors influencing healthcare utilization among Interstate Women Migrants in Kerala. The significance of insurance and the quality of care received were added to the quantitative phase. The data analysis of the qualitative phase also helped in understanding the need for targeted services and policies for women migrant workers.

.PART B: Quantitative

I. Profile of the Respondents

1. Personal Profile

The majority (63.7%) of the participant belonged to the age group of (18 to 25). About 90.6% of the participants were found to be unmarried and the majority having educational qualifications up to upper primary (42.7%)

2. Job Profile

51.3% of the respondents were receiving income equal to or less than 400rs. The work hours of the respondent were reported to be <=8hours for 57.7%. About 53.7 % of respondents were found to be working for 20 to 26 days a month with about 52.3% having work experience in Kerala in between 1 to 5 years

3. Migration Profile

Most of the respondents have migrated from rural areas (92%) as compared to urban areas (8%). The respondents of the present study belonged to six Indian states of more

than half of the total respondents were belonging to four states Bihar (32%), Orissa (21.3%), West Bengal (19.3%) Jharkhand (18%) while about 1.4% and 8% respondents belonged to Karnataka and Assam respectively. The reason reported by the respondents for migration were marriage (23.3%), family (8%), Employment (68.7%). the migration channel utilised by the respondents during migration were Friends (51%), Relatives (28.7%), contractors (14.3%) and Village people (6%).

4. Working and Living Conditions

All of the 300 respondents were found to be provided accommodation by the employer and had access to safe drinking water and toilet facilities. The source of drinking water was through a private tap and the toilet provided were flush systems.

5. Adverse Health Behaviour

34.3 % and 7 % of the total respondents reported having been using tobacco and alcohol respectively.

II. Perceived Morbidity and Health Status of the respondent

1. Health Status of the Respondents

The health status of the respondents as measured using the short-form health survey 12 (SF12) scale, It is noted that the mean score of the overall health status of the migrants is noted to be M=37.8496, which indicates a lower health status. The physical and mental summary score along with the different subscales observed that the respondents were found to have a lower mean score for both physical and mental component score with mental component score (M= 29.3110) being lower than physical component score (M= 46.3882). this could be because they are away from their native place and their socialization is limited to the workers staying in the hostel. The respondent's frequency of visits to their native place is lower due to the fear of losing their job this could also influence their mental health. Physical and mental health domains were further divided into various subscales, it was found that within the subscales the lowest mean score was scored by bodily pain subscale (M=34.8526) under physical and mental health subscale (M=21.8705) under mental health domain while the highest was scored by Role physical subscale (M=42.5883) under physical and Vitality subscale (M=49.0913) under mental health domain. The other subscales under the physical health domain had a mean score of General health (M= 42.4044) and Physical functioning (M= 39.8310)

while the subscales under the mental health domain have a mean score of Social functioning (M= 38.0550) and Role emotional (M= 30.5444).

2. Self-Reported Morbidity and Severity

The Self - reported morbidity among respondents, it is noted that out of 300 respondents 234 of them that is about 78% have reported having some type of morbidity. From which about 30.7% of the respondents perceiving the morbidity to be mild and 69.3% of the respondents perceiving it to be severe. Even then only 44.9% of the respondent is found to be undertaking medication for their current morbidity. Most of the respondents of the present study were found to have some form of illness that were largely job-related and some even perceive it to be serious but there exists a lack of motivation from the respondents to avail health services in the state and in general. Of the 234 respondents having morbidity only 105 chose to be under medication this could be linked to the innate health-seeking behaviour or due to the job factors as well as lack of motivation from part of health care providers to help them achieve illness free lives. Previous studies held in other countries have also yielded similar results when it comes to the number of migrants undertaking medication for self-reported illness and the factors have been to do with the lack of health insurance and low wages.

3. Self-reported Health Issues and Symptoms

The Prevalence of Heath Issues and Symptoms, it is found that the most common health issue as reported by the respondents are general body pain (62.3%). This is very much linked to the work conditions since the respondents are working a minimum 8-hour shift standing. Fever (31.7%) is an important health issue reported by the respondents. This as reported by the respondent is causing Musculoskeletal Morbidities such as Backache (34.7%) and Joint Pain (9.7%). Respiratory problems, ophthalmic and skin morbidity again is very much related to the work conditions where they are exposed to chemicals causing them to have skin and eye irritation. The common respiratory problems reported were Breathing Difficulties (9%), Cough (4%) and Asthma (1.7%) while skin morbidity reported were Rashes (7.7%) and Allergies (25%) the Ophthalmic Morbidity and Dental Morbidity was reported by about 4.3% and 1.3% of the respondents respectively. Injuries (1.7%), burns (1.7%) and fractures (0.3%) were found to be low among respondents which could be attributed to their work as they were not involved in the job that requires more physical strain as compared to other sectors. Gastro-Intestinal Tract

Diseases around to be a common significant issue that was reported by both sectors. Especially about the Loss of Appetite (37.7%) which was attributed to the food being provided to the migrants. These people are not used to the food cuisine of Kerala and most often find it difficult to eat the food provided by the employers and thus depend on junk food. It should also be noted that the oil used for cooking in Kerala is different from elsewhere in the country and this also prevents most respondents from consuming the needed food and causing them to be Nauseous (13.7%) at times. This is found to have a huge impact on their overall health with respondents reporting about gastric issues and lack of strength to perform their daily tasks. The food option for them is limited therefore they either skip it altogether or consume Junk food. Other Gastro-Intestinal Tract related Diseases faced by the respondents are Abdominal Pain (7.3%), and Constipation (1.7%)

Reproductive health issues are another significant area of focus. The major issues reported by respondents are Irregular menstrual cycle (44%), Pain During Menstruation (36.7%), Genital Itching (30%), Low Backache During Menstruation (25.7%), Urinary Tract Infections (19.7%), Vaginal Discharge (15.3%), Redness of Genitalia (4.7%) and Inability to Conceive (1.7%). Reproductive health issues are common among women, they seem to affect women irrespective of their socio-economic status. Even then migrant women by default are at higher probability of being affected by these issues simply because of ignorance and lack of access to healthcare services. Most of these women come from the poorer part of the country where they are prone to unhygienic menstruation-related practices. The lack of awareness of the extent of these issues leads them to be silent till it is unbearable. Most women have reported ignoring symptoms such as intense itching, vaginal discharge and irregular menstrual cycle viewing it to be normal and attaching to the bodily change due to migration to Kerala. Women in the urban poor setting tend to have a high prevalence of self-perceived reproductive morbidity (Suneela Garg& Meenakshi et.al, 2001). Many studies related to migrant women have exclusively focussed on understanding their sexual and reproductive health yet less focussed on the intervention to be provided. While Women with access to sanitation is in a better hand, it should also be noted to provide them with the awareness and resources to combat these issues.

Respondents were also observed to have a certain medical condition such as Anaemia, PCOD, Hypertension and Obesity which was reported by 15.7%. 11.3%, 3.7% and 2.3%

respectively. Though PCOD is confirmed only by 34 respondents, most of the respondents did have symptoms pointing to PCOD. The lower reporting could be because of the lack of health-seeking by the respondents for the same. Women, in general, are prone to anaemia due to a lack of access to nutritious food. The Northern State of India especially reports a high level of anaemia among women, along with this is the limited food intake by the respondents can lead to more health problems for the respondents. The respondents are neither found to be aware of the free medications provided by the PHC's nor are they approached by ASHA workers for any kind of health promotion.

There exist significant differences in the level of psychological issues faced by migrants according to the place of work and the sector where they are employed. The behaviour of contractors, Unfavourable attitude of contractors, the behaviour of supervisors, the presence or absence of subgroup of relative and Unfavourable attitude of local co-workers were found to have a significant impact on the level of alienation, depression and loneliness experienced by the migrant labourers (P & S. K., 2016). Stress (24%) and Anxiety (19.3%) were found to be significant when looking at psychological symptoms, the workers are often faced with job insecurity as well as prone to abuse from the employer this could be a reason for raised stress level. The same symptoms experienced by the respondent could be one of the factors leading to respondent's Sleeplessness (15%), Restlessness (9%) and Fatigue (4.3%). Most of the respondents did share their feeling of not being able to visit their family often. It should be especially noted that most of them were unmarried and their comfort comes from being with their family. The married respondents having their husband staying and working in Kerala was placed at a better end than the former group.

The migrant's native state profile is different from the host state and therefore the health profiles as well as the health issues. This is especially relevant to the public health domain where there is always an underlying chance for an epidemic breakout. Therefore, it is very much the need of the hour to address the issues of these women to ensure there are no gaps.

III. Health Seeking Behaviour of the Respondents

1. Overall Health seeking behaviour among the Respondents

The level of health-seeking behaviour among respondents as measured by illness seeking behaviour scale, it is noted that about 40.7% of the respondents reported having moderate health-seeking behaviour followed by 34% reporting to have low health-seeking behaviour and only 31% have reported having high health-seeking behaviour. Health seeking is influenced by a variety of factors including the awareness of the health facility, financial factors, transportation and other job-related vulnerabilities. These can have an impact on the workers to access health care during an illness. The migrant workers in general have a poor pattern of health-seeking behaviour which could be attributed to their fear of losing their work and daily wage which forces them to depend on the pharmacies and other alternate care at the onset of diseases symptoms(Sreejini, 2012).

2. Dimensions of Health Seeking Behaviour

a) Actions Undertaken during Illness

The Actions Undertaken during Illness, it is reported that out of 300 respondents 267 which is about 88.3% have attempted to treat their illness during their stay in Kerala. The respondent seems to take more time to receive care that is about 39.3% have reported taking at least 3-7 days to opt for care followed by 18.7% taking more than 7 days to resort for care all the more it is also observed that the respondent resorted to health care only during the mild incidence of disease and its symptoms or when the illness has reached a serious stage. This could be due to the lack of severity attached to the health issue and normalization of illness to be part and parcel of daily life. It is also observed that 57.7% of the respondent undertake medication to relieve symptoms and 46% do not complete the course of treatment whereas 25% of the respondents take medication to recover. This indicates that most medication undertaken by the respondents are only halfway till they can relieve themselves from the symptoms that hinder their productivity and less focus is given on complete recovery.

When it comes to treating undertaken, there is a visible difference in the number of people resorting to hospitals and clinics vs those undertaking self-medication and those relying on the local pharmacists. the type of treatment undertaken by respondents in times of an illness. Out of 267 respondents, 30% undertake treatment from the local Pharmacy Without A Prescription but Consultation with The Pharmacist followed by 20.1% depending on Traditional Healers, Pharmacy Without A Prescription and Consultation with The Pharmacist and 15.2 % Self-Treatment with Herbal and

Chemical Medicines in Home while 15.7 % and 19% of the respondents depend on General Practitioner's Office, Health Centre, Emergency Room Clinic, Private or Governmental Hospital. Self-medication becomes one of the primary health-seeking actions undertaken by migrants when confronted with a health issue. Similar studies have reported, increased preference of migrants to depend on pharmacies for their health issues which are indicative of Self-medication being one of the most common health-seeking behaviours. The respondents visit the health centres only when their health conditions deteriorate and were also found to approach private practitioners and clinics than government healthcare centres. Individual factors such as health insurance, time and distance to health centres and consultation fees along with the ease of accessibility to the healthcare services were found to be significantly influencing health-seeking behaviour (Aung &Pongpanich, 2009).

Health care providers from health care consumers' viewpoints

i. Patients Previous Experience of Services Consuming

The previous experience of service consuming among the respondents, It is found that out of the 267 respondents 229 have reported to have previous experience with the health care service providers in the state. The respondents have reported finding the health services to be somewhat useful for their health problems with 27.9% reporting to be very much satisfied with the Behaviour and Accountability of the health service provider as well as have reported having always (24%) Received Needed Care at Right Time. But when it comes to Maintained Dignity and Respect of the respondents during the consultation, 30.1% of the respondents have reported having very low satisfaction. Overall, it is found that the respondent does find the health system to be useful and catering to their needs still yet there are factors such as the attitude of the health care professional that needs to be looked into to prevent discrimination against these migrant workers.

ii. Consumers Evaluation from Health Care Providers

Consumer evaluation of the health services helps to understand the factors that the consumer finds important for utilising the health services, it could be noted that Behaviour of Health Care Providers (37.3%), Physical Environment of Care Providers' Centres, Attractiveness and Convenience (32%), Cost of Health Care (34.7%) and Reliability of Health Care Results (44%) were the factors the respondents found to be

very much important in evaluating health services while Time taken for Receiving Health Care Services (43.3%) and Quality of Received Services (34.3%)were considered much and somewhat important in evaluating health services respectively. As noted here these factors also act as barriers that prevent them from approaching for health services. Though the health system works to provide treatment free of cost to the public irrespective of being migrants these services are not well utilized by the migrant due to distance and long waiting time thus pushing them to resort to private clinics that charge them a hefty amount per consultation.

b) Psychological Factors

The psychological dimension of health-seeking is very important in understanding the innate factors that push or prevents people from approaching the health care service providers in times of a health issue. it is noted that disease acceptance of the respondent is found to be very low with about 36.3% rarely accepting their health issues. The respondents reported it is somewhat (28.7%) important for them to be Maintain Health for their Community, Family and Friends. The respondents tend not to believe that their health has a role to play in the community or among their family and friends. The value that the respondents' place on health is also reported to be somewhat important to them (32.3%). This could be due to the non-health-related priorities in life they prevent them from viewing one's health as an important component, this is also congruent with studies carried out in other countries where women are found to be less worried about their health as compared to men. The respondents are also found to be somewhat (30%) afraid about their treatment consequences and death this could a reason that prevents them from utilizing health services. The possibility of them having to undergo heavy treatment consequences prevent them from health-seeking. The stress of illness and the treatment (32.3%) and Shame in Expressing their Disease, Talking About It and Getting Treatment for It (46.7%) is also reported to be much important to them which add to their fear thus preventing them from approaching the suitable health care services. The fear of being caught with a certain illness could lead them to lose their job especially with respect to the seafood processing sector where hygiene becomes of utmost importance. The migrants are often under the constant health radar of the employers who push them to undergo repeated tests for STD's and other health issues. Gender psychology plays a significant role in understanding why women tend to give less

importance to their health as well as find health issues to be a normal event in everyday life.

c) Individual Factors

The individual factors have an important influence on health-seeking as it helps in evaluating the need for care and the consequences that follow it. This factor is highly connected to the Anderson model of health care utilization which considers individual characteristics as the predisposing factor that would push people to seek health. From the graph, it is noted that the Treatment Period for 31.3% of the respondents remains to be around 3-7 days with most people not having prior experience of a particular illness (42%) and perceiving their Disease Severity and Its Symptoms (55.3%) to that of average concern. The respondents also have reported having received only somewhat information about the disease and Needed Care Before Receiving Care (36.3%), They have not reported having been Suffering any Another Disease (42%). Overall, the respondents have reported their State of Health to be good (42.7%). The probability of visiting healthcare reduces with the increase in perception of a positive health status all the while overlooking their current morbidity and need for care.

d) Socio-Cultural and Familial Factors

Social, cultural and familial factors can influence the health-seeking behaviour of the individual, there is a cultural difference that exists between the migrant state and Kerala, many practices that have been following in the respective native state of the migrant might be perceived differently in the host state. Family issues can prove to be a barrier to health-seeking as the financial priority overpowers the health needs therefore they assume the health issues to be normal and part of life. This is true especially with women who as part of the socialisation learn to suppress their needs. About 59.3% have reported believing that their Job Responsibilities and Family act as a barrier to care-seeking. This could be the reason why 61% of the respondents have reported Hiding Disease and Tolerance as a Desirable Feature. The respondent is found to be much Depend on family members in Health Care Receiving (58.7%), this can be seen especially with respect to health-related decision making. The respondents have reported having returned to their native place for seeking healthcare. The health-related expenditure is influenced by family members as reported by other studies as well.

e) Situational Factors

Situation factors include all those scenarios that have influenced them in health-seeking. This ranges from involvement in daily activities to resource availability for seeking care and to that of reliability and confidentiality. Health seeking is very much influenced when illness and its symptoms hinder their daily activities (56%) and they are always in a situation to receive medications easily and without a prescription (40%). It could also be inferred that Confidentiality of health-related information, Distance to the nearest health facility, Cost of Care and respondents Previous Experience of health care utilization also plays an important role as situational factors in determining whether to seek health in times of an illness. This is very much present in terms of maintaining the confidentiality of information related (40%) to their health issue since the migrants are in constant fear of deportation due to illness and this often prevents them from seeking health. Distance (69%) and cost of care (156%) is indeed an issue and very much influencing factor when it comes to migrants especially women since they are paid less than their counterparts and are often experience double discrimination by the virtue of being a migrant and being a woman. the low pay combined with the high cost of health-seeking puts them in a situation where they resort to self-medication. The distance matters since the longer the distance more chances of them having to take leave ultimately leading to loss of pay therefore as reported the respondents do feel that distance and cost influence their health-seeking. Previous health-seeking experience (36.5%) is of utmost importance in understanding the reason behind low health-seeking behaviour since health-seeking is a combination of different dimensions it is important to look at the resources at play during a health-seeking experience and the barriers that prevent them from seeking care.

f) Marketing Factors

It could be noted that 45.7% of the respondents have reported low when asked about the affordability of health care service indicating that they could not afford the charges of health care when they needed it whereas only 1.7% of respondents have reported that they can afford health care service all the time when they need it. Similar results have been observed when it comes to respondents thinking of utilizing healthcare even before approaching health facilities. It is found that about 47.3 % have reported thinking quite compared to whether they could afford the healthcare service charges before visiting a health facility. The living standard in Kerala is one of the highest in comparison with other states, this by virtue would have an impact on the health care system as well.

Healthcare costs can become a burden for migrant workers who are highly dependent on private clinics for their health needs than government facilities causing them to resort to self-medication and local pharmacists.

The respondent's decision making is found to be less influenced by advertising with only 16.3% reporting to have their health care decisions very much influenced by advertisements compared to 44.3% reporting advertising to not influence the health care decision making. It is also noted that they receive very limited information for receiving care with about 46% reporting to have received low information on receiving care when they need it. This could also be due to the less exposure of the respondents to healthcare advertising along with less awareness carried out by neither at the industry level nor by the ground-level health workers. Even though there is a strong primary health system prevalent in the state, there is found to be a lack of address towards the health needs of migrant women especially those working and living within the industry premises. Most of their source of health information comes from the internet 41.3% followed by friends 39% which may not be a completely reliable source. Therefore, there need to be mechanisms at the ground level to extend help to these populations for them to be aware of the health-related services as well as to promote them in seeking health when needed.

IV. Health Care utilization

1. Previous Hospitalization details of the respondents

the Previous Hospitalization details of the respondents, it is observed that the respondents were aware of the nearest health facility (75.7%) as well as the location of the government facility (53.2%). Even then the number of respondents opting to visit the near health facility was found to be very less that is about only 31.7% reporting to have visited the health facility for their respective health issue in the last six months though about 234 respondents reported themselves to have some form of morbidity. The majority of the respondent that is about 75.8% have been to the health facilities for consultation on various health issues while 19.6% reported having undergone minor treatment and only 4.3% reporting to have major surgeries. About 66.3% of the respondents were found to spend up to 600 rupees every time they visit the health facility. this was especially because of their dependency on private clinics that charge them higher than government facilities. The respondents are also forced to buy

medicines from a local pharmacy which again increases the cost of health services. Though government hospitals have low consultation charges as well as free medicines, the respondents depend more on private clinics due to the work hours as well as the waiting time.

2. Barriers to Utilization of Health Services

The Self-Reported Barriers to Utilization of Health Services among respondents, it was noted that Low Illness Severity Perceived (56%), Self-Medication (52%), Low Wage (48.3%), High Service Charge (46.3%) and Long waiting time (32.7%) were reported as the major reasons for not seeking Healthcare Services. This was similar to the finding by studies on health care utilization which pointed towards self-medication, employer factors and health facility-related factors to be an important determinant for Health Care Utilization. The other reasons reported by the respondents were Lack of Free Time (21.7%), Long Distance to Health facilities (15.3%), Rough Attitude and Discrimination from Service Providers (14%), Language Barrier (12.7%) and Unavailability of Free Medicines (10.7%). Equity in health care can be achieved by integrating migrant-friendly policies in the health care system. The efforts to help migrants break down language and cultural barriers can improve the patient-physician communication process (Zhong et al., 2018).

3. Health Insurance

The government of Kerala has launched AWAZ Card Yojana for migrant workers to help them gain health insurance. This card deems them to be registered with the government so that in times of a health issue they can be provided with the needed financial assistance. Only 81% of the total respondents are aware of the health insurance scheme of which only 120 workers have reported to be enrolled in the health insurance scheme. Only a few respondents were found to be enrolled in ESI (19.7%) and government health insurance(24.3%). This is in the context where the government of Kerala has made it mandatory for all the migrants to register with the state and the AWAZ card yojana. The ESI benefits are also found not to be benefiting the respondents as they are not aware of the procedures and process for availing for the same while those who have availed have not yet got any benefits from the same. The majority of the migrant's workers do not work permanently in the same industry for long and therefore the new migrants do not have a channel for which they could be aware of their rights.

The ESI and PF benefits are alien to them since for most of them this is their first job and they lack knowledge regarding the same, most often they do not understand the mechanisms in place. Therefore, it becomes the duty of the employer to convey these rights to the workers to help them to better make use of these schemes in times of a health issue. Though the government has created awareness on AWAZ cards and has set up nodal agencies to help the migrants, not all of the workers have complete information on the same. Most of them believe migrating to Kerala is equivalent to earning more for their family and illness is a burden they simply cannot spend more time and energy on.

4. Satisfaction and Quality of Health Care Services

The Health Care Service Satisfaction Among Respondents as measured by Patient perceptions of health care quality scale. About 51.6% of the respondents have reported having moderately satisfied with the health care services followed by 34.7% reporting to have low satisfaction with health services while only 13.7% reported being highly satisfied with the health services. The satisfaction as noted here is highly dependent on many factors such as medicine availability, infrastructure, doctor behaviour and staff behaviour. The most important factor in any health-seeking is the trust the people have towards a health care system. Kerala is well known for its health care system; it is indeed considered as the most efficient health system in the country even then certain sects of the population do not receive the complete benefits bested upon by the government. Migrant workers, especially women migrant workers working in these industries are especially among the above-said population. It is because they neither belong to the unorganised migrants nor to the organised workers, they are in constant friction juggling from one company to another and not settled in one area. Most often they are overshadowed by the visible migrant population settled in the cities. They do not get registered even though it is mandatory, they are brought in by the contractors and are supplied to the companies as and when necessary. Some of the workers that reach have not even acquired legal maturity but claim to be above 18years of age.

The overall quality of health care along with the quality perceived for each subscale being Medicine Availability, Medical Information, Staff Behaviour, Doctor Behaviour and Hospital Infrastructure. Most of the respondents have reported the overall quality of the health service to be moderate which is about 47.3%. when it comes to the

subscales it is observed that the majority of the respondents have reported the quality to be moderate for the Medicine Availability (52.4%), Medical Information (53.3%), Hospital Infrastructure (46.7%) and Doctor Behaviour (45.9%) whereas the respondents have reported the quality of the staff behaviour (48.9) to be very low. Medical information, doctor and staff behaviour are factors that should be looked up seriously since they can motivate migrants to seek care during a health issue. Most of the time migrants deny themselves health services because of their fear of the treatment consequences. The language and cultural barriers sometimes lead to them obtaining incomplete medical information thus causing dilemmas that never gets resolved. Even during the Focus group discussion, it was reported by many that they are aware of the hospital and the free medicines but what prevents them from approaching health care is their fear of being treated differently. Social exclusion and discrimination do have a role to play when it comes to health-seeking among migrants as proved by many studies. By the virtue of being migrants, their health issues are given more emphasis as arising from lack of personal hygiene which could make them feel embarrassed and shameful in revealing their health issues and seeking healthcare.

V. The Relation between Perceived Morbidity, Health Seeking Behaviour and Healthcare utilization

1. Health Status, Perceived Morbidity and Health Seeking Behaviour

The migrant population being the non-native population, are vulnerable and at-risk to be exposed to many health problems. When internal migration becomes a survival strategy in developing countries to enhance livelihood and job opportunities, these workers will inevitably have health problems different from that of the native population (Akinola et.al, 2014). The inability to cope with physical and psychological stress, unhealthy sexual practices, and frequent inbound migration are some of the major factors influencing their health. (Gupta et.al, 2014). Health seeking behaviour refers to the actions undertaken by the respondents when met with a health concern. Results showed, there was a significant relationship between Health Seeking Behaviour and Health Status (p=.042) while there was no significant relationship observed between Perceived morbidity and Health Seeking Behaviour(p=.062) Health status and Perceived morbidity can act as an important determinant for seeking healthcare services when needed. Health status is indicative of their present state of wellbeing and therefore will influence

health-seeking behaviour as it helps them to be productive at work. The existing morbidity long with the perceived severity is becoming an important determinant while choosing the type of treatment. The majority of the respondents have reported taking self-medication in times of health issues primarily because of low perceived severity, health becomes a second priority of the economically disadvantaged migrant community. Migrants are deprived of culturally competent care, face discrimination and find themselves in situations where they are not able to access or afford the services (Akinola et.al, 2014).

2. **Health Status, Perceived Morbidity and Health care utilization**

Concerning Healthcare utilization, the results indicate that there exists a significant relationship between Health Status and Health care utilization(p=.023) as well as significant between Perceived morbidity and Health care utilization(p=.000). healthcare utilization is largely influenced by a lack of awareness of the nearby local health facility(Gupta et.al, 2014). women in the urban poor setting tend to have a high prevalence of self-perceived reproductive morbidity yet they have a lower level of healthcare utilization. This could be attributed to a lack of preventive and promotive strategies available concerning reproductive morbidity and healthcare-seeking behaviour to reduce the magnitude of the problem (Suneela Garg et.al, 2001).

3. **Health Seeking Behaviour and Health care utilization**

There exists a significant correlation between Heath seeking behaviour and Health care utilization (p=.007). This is indicative of higher the health-seeking behaviour higher would be the healthcare utilization. While Health seeking behaviour could be attributed to individual factors, healthcare utilization is highly influenced by the migrated area and the services available thereof. The healthcare service utilization rates in general, are found to be very poor among migrants which could be attributed to them being alienated from the government health system due to their temporary status as well as their work-related factors such as the work hour and distance to the nearest health facility. The most significant reason for people not availing of health care services can be attributed to their lack of understanding and familiarity with the public health care system(Priebe et al., 2011).The rate of hospital use is lower in the case of migrants as compared to natives (Baglio et.al., 2010).

VI. Testing for the difference in Perceived Morbidity, Health Seeking Behaviour and Healthcare utilization among different sectors

1. Testing for the difference in Health Status and Perceived Morbidity among different sectors

The result indicates there exists a significant difference in mental health status across different Job sectors ($p = .033$) while there was no significant difference in Physical Health status across different Job sectors ($p = .954$). The respondents belonging to the textile sector were found to have a higher mean score of mental health status indicating better mental health than respondents belonging to the seafood sector. The difference can be attributed to higher working hours and daily target achievement for the workers in the textile sector. Migrants are vulnerable to mental health problems primarily as a result of their living and working conditions with women migrants residing in urban areas found to be having lower mental health status than rural areas. The workers in the textile sector are exposed to higher occupational stress than the seafood sector, also the evident difference in workhours among migrant and native works can cause them to have burnouts. The mental health status of the woman migrants is highly influenced by their working and living conditions. The quality of life, migration-related push factors and health status also have an influence on the mental health of women migrants implying that enhancing the quality of life and improving the working and living conditions can enhance the mental health wellbeing of the women migrants (R S, Unisa, & Jose, 2014).

2. Testing for the difference in Health Seeking Behaviour among different sectors

Migrants tend to have poor health-seeking behaviour due to the socio-economic background from which they migrate. Health-seeking behaviour is highly influenced by individual factors and their value attached to health. The socio-cultural background of the migrants has a lot to do which the type of treatment undertaken by the respondents. From the results, it was evident that the respondents across different sectors were found to not have a significant difference in health-seeking behaviour across different sectors ($p = .599$). The insufficient information migrants receive about lifestyle, health issues and health risks along with their lack of knowledge regarding their rights and privilege to safe working conditions and public health services in the host region plays an important role in determining the health status and their health-seeking behaviour. The migrants are often left with

no choice but to continue with their prevailing health conditions until it gets worsen due to their restricted access to formal healthcare services (Bener, 2017).

3. **Testing for differences in Healthcare utilization among different sectors**

   The result indicated a significant association between the job sector and health care utilization ($p < .05$) with the respondents belonging to the seafood sector more likely to utilize health care services than respondents belonging to the textile sector. This could be due to the location of the nearest healthcare facility. The workers in the seafood sector had access to multiple healthcare facilities nearby both government and private. Also for workers employed in the textile sector, there is a health clinic inside the facility which they have access to regularly. This could be a reason for reduced healthcare utilization.

VII. Testing for the difference in Health Seeking Behaviour and Healthcare utilization among Personal Variables and Job Variables

1. **Testing for the difference in Health Seeking Behaviour among Personal Variables and Job Variables**

   Health and social status are related and can have adverse health effects on unskilled and low-level migrants(Nwajiuba et.al, 2007). Migrant's fear of losing their job and wages could be attributed to their poor pattern of health-seeking behaviour (Sreejini, 2012).From the results, it is observed that that was no significant difference in Health Seeking Behaviour among Personal Variables and Job Variables

2. **Testing for the difference in Healthcare utilization among Personal Variables and Job Variables**

   From the results, it is observed that that exists a significant difference in Healthcare utilization among certain Personal Variables and Job Variables. The variables which showed a significant difference were, Place of Residence, State of Migration and work hours. It was noted that respondents belonging to rural areas, those working for less than 8 hours a day and those migrants who have migrated from Bihar were more likely to utilize health care services. Migrants have a poor understanding of health care services. Most of the migrants do not have access to health services and those who did access were not until their health situation got worsened (Khongthanachayopit&Laohasiriwong, 2017). They tend to underreport the medical condition to avoid hospitalisation. This can be attributed to the lack of medical

insurance coverage for migrant workers (Lu et.al, 2014). Studies have found Lower levels of inpatient care utilization is higher among low-paid and less educated female migrants as they were more likely to be uninsured and was forced to pay out of pocket (Mou et al., 2009; Zhang et al., 2014).

VIII. Factors Influencing Health Utilization among Respondents

The Binary logistic regression conducted to examine the factors that influence the health care utilization of the respondents revealed that out of 14 independent variables, 10 of the independent variables made a unique statistically significant contribution to the model. These were Age, Educational Qualification, Work Hour, Health Facility Awareness, Government Health Facility Awareness, Health Insurance, Government Health Insurance, ESI, Health Seeking Behaviour and Health Issue while Marital Status, Place Of Residence, Income, Work Hours and Health Status were not significant predictors of Health Care Utilization.

The strongest predictor of Health Care Utilisation was found to be Health Insurance indicating that respondents who were enrolled in health insurance were more likely to utilize health care facilities than those who were not enrolled in health insurance controlling for all other factors in the model. Government health insurance and ESI were reported also to be two significant predictors for health care utilization. Both of them indicating higher utilization for those who have enrolled for the same. this finding has been corroborated by similar studies focussing on understanding the influencing factor for healthcare utilization. The studies (George, 2018; Lu et.al, 2014; Idris et.al, 2017; Lam & Johnston, 2012) have found a significant influence of health insurance on healthcare utilization, primarily because the migrant population are often at a financial disadvantage and therefore there need to utilize health service comes at the cost of their daily bread. Health insurance can help them have better access to health services at cheaper or free of charge health services. The migrants having higher Educational qualifications were more shown to utilize health care services. literacy is found to be an important predictor for woman's likelihood to access healthcare, the study conducted on Nepali women with low educational attainment to understand the relationship between literacy and healthcare-seeking found significant associations between literacy skills and health behaviour. The study found that health-related decision-making power is positively associated with Literacy (Lam et.al, 2013).

When it comes to migrant's attributes, it was observed that the respondents having more than one health issue were found to utilize Health Care Services when compared to respondents recording a single Health Issue and that the age of the respondent was also found to have a significant influence in utilizing health care where higher the age indicated high chances of health care utilization. Health seeking behaviour did also become a significant predictor with respondents with high health-seeking behaviour more likely to utilize health services.

Awareness of the nearby health care facility also has a significant influence on the health care utilization, especially if it is a government health care facility as it could help them avail subsidized medications and cheaper service charges (Babu et al., 2018; Dodd et al., 2017). Equal access to health care requires a better understanding of health insurance coverage among migrant populations, raising greater awareness of health insurance and its costs. A study in Indonesia focussed on understanding the importance of how socio-demographic factors, health behaviours and health status affect health insurance coverage (Idris et.al., 2017). even workers in high-income countries like the Czech Republic, where linguistic barriers and a lack of awareness about public health insurance have excluded eligible immigrants from the public health insurance system (Dzúrová et al., 2014).

The influx of migrant population is inevitable and that that the coming years will witness an increased demand for migrant workers, the state needs to develop migrant-friendly policies to strengthen and sustain the growth trajectory of the Kerala state as well as the migrant's state of origin (P A & P A, 2017). Instead of viewing Internal labour migration as a determinant of health in and of itself, the government should focus on Targeted public health interventions to understand the determinants of health for the internal migrant labours such as the Disease transmission among migrant workers, and between migrant workers and their households and communities of origin (Dodd et al., 2017).

Conclusion

Implications of the study

- **Implication for Social Work Practice and Education**

Social workers play a significant role in addressing the issues of migrants irrespective of gender. The role of the social workers is even more emphasised when it comes to women migrant workers as they are highly vulnerable to exploitation and discrimination. Even though there exist various civil society organisations and government-funded projects, there is no clear mention of the role of social workers or the need for the same. Migration as a field of practice for social work is only emerging and has to be viewed as a multidisciplinary phenomenon that requires collective action. The educational curriculum of social work though addresses women issues and issues of vulnerable populations not much attention are paid to migration-related issues. For this issue of the invisible population to get the attention it needs, the curriculum should have a focus on migration dynamics and its relevance in the present scenario.

- **Implication for research**

The research on internal migrants in Kerala has largely focussed on male migrants and the issues and challenges faced by them. The studies on women migrants have focussed on exploitation and discrimination than their health concerns. There also exists a dearth of research with regard to the health-seeking behaviour and health care utilization of women migrant workers in Kerala. For successful implantation of services for these women migrants there needs to be studies that advocate the need for the same. The studies focussing on women migrants with respect to their socio-demographic variables can help in understanding the barriers they face in utilizing health services which indeed will help in formulating a better health delivery mechanism.

- **Implication for policy**

Policies of the government should be gender-sensitive to accommodate the need of migrant women. the focus should not only be limited to provide maternal and reproductive services but move towards inclusive healthcare for all irrespective of administrative status. There need to be safety nets in place to prevent the exploitation and discrimination faced by women migrant workers. The study had revealed the need for a gender-sensitive approach to migrant policies in reducing health disparity. The policies that are largely applicable to general workers are often ignored in the case of women migrant workers. The policies play a key role in determining the level of integration of women migrants into society and the study highlights the need for the same.

- **Implication for Healthcare System**

Frontline workers play an important role in delivering healthcare services to vulnerable population yet their presence are often absent in the migrant community. The research has revealed the need for the health system to be strengthened for effective delivery of the services. The presence of migrant medical officers can help in accelerating the process but this should not be the only mechanism, there should be countermeasures within the community to help check the living and working conditions of these women migrants in order to promote their health status and prevent a public health emergency. Regular health camps and screening can help in the early detection of illness and this should not be limited only to larger migrant pockets but to every identified migrant pocket. The rights of the migrants should not be ignored and proper consent and information need to be provided to them before undertaking health screening. Migrants should not be deprived of the rights they are entitled to them by the government with regard to the administrative status.

- **Implication for state and local government**

District administration has a very crucial role in addressing the issues of migrants especially women migrants as they are better placed in identifying the organisation where these workers are employed. This knowledge should be effectively utilized to provide better support for migrants in accessing health services. The government should also develop ways to maintaining social and financial links with sending states, this will help in opening the secure migrant channel and better registration of these workers to the government. the agency employing migrant works should inform the local administration this can help in reducing exploitation of the workers.

Suggestions based on the study

1. For women migrants' workers to benefit from the government policies their contribution towards remittances and national GDP needs to be recognised. This requires the need for a better-structured data collection as part of the Census And National Sample Survey to understand the reason for women migration. this also puts pressure on the regional government to maintain data on women migrant workers.
2. The registration of women migrants are severely low and this could be attributed to the unorganised migrant pockets as well as the unchecked contractor.

Therefore the need for regular inspection at worksites and a mandate to every industry to produce proof of employment where women workers are especially employed.

3. Lack of political will and ignorance among illiterate migrants pushes them to undergo exploitation. Establishing a formal migration channel/ portal as well as providing them awareness regarding their rights can help women migrants in accessing fruitful employment as well as prevent them from being exploited by the employers.
4. Migrant helpline and support groups are a solution to help migrants in addressing their concerns but are often understaffed. Therefore the need for establishing a migrant help desk that can reach out to these workers.
5. Increasing awareness regarding the health services available to them not just in terms of maternal reproductive services but in terms of general health concerns as well preventive promotive services offered
6. The health Services should be made flexible to meet the needs of the workers, regular screening for health issues can help in better preventing a public outbreak but should not at the violation of their fundamental rights. Health services should be equipped to handle the health issue of women migrant workers with irregular status as well as be able to develop a consensus with the workers to enhance the health delivery process. This may even require the system to realise that these workers may not be comfortable sharing information with male doctors.
7. The Frontline Health Workers such as the ASHA workers should be given sensitization training to be able to successfully manage the concern of the migrants and to ensure the service provided are culturally sensitive and apt.
8. The language barrier is a challenge for the ASHA workers which prevent them from effectively communicating to these workers, therefore the need for migrant link workers who can be taken from the respective pockets who can be trained to the representative of their respective settlement. This can help in the effective flow of information as well as in enhancing trust within the migrant population.
9. Providing language classes for the migrant as seen with some organisations in Kerala can help in making these workers independent and in providing them with the opportunity to access health care services. This might not always be

feasible and therefore the need for Integrating services to be present in hospitals could help in effectively communicating their health concerns to the doctors.

10. Health insurance and health care utilization are two sides of the same coin, therefore the need to create awareness on the existing government insurance and how to utilize the same as well as help these women employed in the sector with ESI benefits to better utilize these services for their benefits.
11. Community play an important role in promoting health, migrant pockets located deep within the local community should be made accessible and acceptable to the migrant workers to help them in approaching the respective administration for their concern.
12. Effective monitoring systems within the community can act as watchdogs to help prevent exposure of women migrants to harassment, exploitation and trafficking.

Limitations

Migration channels utilized by the majority of Women migrants are through contractors and are therefore highly scattered. Women migrant pockets are not well organised, unlike their male counterparts. Therefore for establishing the sample frame the researcher had to resort to probability sampling. Non-probability sampling could have helped in obtaining data from a wider sample. Inclusion of other sectors where women migrant workers are employed could help in differentiating the job sector-related differences in health-seeking and health care utilization. The research has limited the study to Ernakulam and Trivandrum due to the presence of a larger number of migrant pockets, these could be expanded to other districts as well.

Recommendation for Further Research

Health seeking and Healthcare Utilization of Women Migrant workers is a less explored topic in Kerala. Therefore the need for studies that focus on understanding the health care needs of migrant workers. the focus should also be on public health and effective intervention to help migrant communities in tackling health concerns. The future research could focus on the district with lower migrant pockets to understand the pattern of health-seeking and health care utilization. The same data could also be used to understand the difference in terms of migrants located in the district with larger pockets as to smaller migrant pockets. This could help in understanding the community

dynamics underplay. The sector-wise difference by including more job sectors where migrant women are largely employed could reach out to a larger sample. Marital status and health is an import area to be explored when it comes to Women migrant workers. due to the increased migration of unmarried women workers, there can be studies that compare the health needs of these two groups. Studies aimed at the formulation of training packages for civil society organisations in creating awareness of their rights and grievance redressal mechanism is also significant in addressing the health concerns of the migrants.

The role of frontline workers should be explored to understand to help understand the challenges faced by them. This could also help in formulation training packages for the frontline workers to help them be sensitive to the needs and plights of the migrant community. The role of migrant medical officers are crucial in addressing the issues in Kerala, therefore there requires an evaluation study based on the migrant pilot project in Ernakulam by the National health mission which indeed would help in enhancing the health delivery mechanism. The health-seeking and healthcare utilization from the perspective of health professionals in Kerala could help in understanding the health service providers challenges which would then help in framing an effective health delivery mechanism.

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APPENDIX

Appendix- A

Details of the Publication

1. "Reproductive Health Vs Overall Wellbeing: Systematic Review Of Studies On Women Migration And Healthcare Utilization" in the *International Journal of Migration, Health and Social Care* with ISSN: 1747-9894
2. "Perceived Morbidity and Health Seeking Behaviour of Women Migrant Workers: A Public Health Focus" in the *Journal of Social Work Education and Practice;* listed under the Emerging Sources Citation Index under Web of Science Core Collection with ISSN: 2456-2068
3. "Perceived Morbidity and Healthcare Utilization of Women Migrant Workers: a public health focus" in DYUTI 2020 National Conference on Migration and social inclusion conference proceeding with ISBN 978-93-89515-16-9.
4. "Social work and Referral Services in Enhancing Migrant Health Services: A Conceptual Paper" in Educere- BCM journal of social work with ISSN 2249-1090

Details of presentation

1. Paper presented on "*Women Migration and Climate Change: Public Health Focus*" in the National Conference BHARATHION 2019- for the nation on the theme "Green Social Work: Emerging Trends and Prospects" on Migration and Social Inclusion: Perspectives for Human Rights and Social Work Practice" held on 18th and 19th December at Bharat Mata College, Kochi Kerala
2. Paper presented on "*Perceived Morbidity and Health Care Utilization of Women Migrant Workers: A Public Health Focus*" during DYUTI 2020, "National Conference on Migration and Social Inclusion: Perspectives for Human Rights

and Social Work Practice" held on 9th and 10th January 2020, at Rajagiri College of Social Sciences (Autonomous), Kochi, Kerala

Appendix- B

CHRIST
(DEEMED TO BE UNIVERSITY)
BANGALORE - INDIA

CENTRE FOR RESEARCH

CU:RCFC/00026/12/18 7 DECEMBER 2018

Ms. M L PARVATHY
Reg No. :1730089,
Department of SOCIOLOGY AND SOCIAL WORK
CHRIST (Deemed to be University), Bengaluru

Sub: Ethical Approval of the Study Titled "Perceived morbidity, health seeking behaviour and Health care utilisation among inter-state women migrant workers in Kerala".

The Institutional Ethics committee has reviewed your application for ethical clearance for the Study titled "Perceived morbidity, health seeking behaviour and Health care utilisation among inter-state women migrant workers in Kerala"

The committee has cleared your proposal for data collection after assessing the ethical aspects.

Sincerely,

T.S.Sam

Dr Tony Sam George
(Member Secretary to Ethics Committee)
Additional Director
Center for Research
CHRIST (Deemed to be University), Bengaluru

Scanned with CamScanner

Appendix C

Informed consent form

I am Parvathy M L, pursuing PhD in Social Work from the Department of Social Work, Christ (Deemed to be University), Bengaluru. As part of my thesis I am doing a study on Perceived morbidity, health-seeking behaviour and health care utilization among women migrant workers in Kerala under the guidance of DrHemalatha K, Associate Professor, Department of social work, Christ Deemed to be University.

Purpose of the Study:
The primary purpose of the study is to understand the health and health care needs and utilization by inter-state female migrants in Kerala. Most often the female migrants are not considered while formulating the policies and the gender sensitivity is not maintained this is due to the major presumption that female migrates as dependents and not as the economic head. This reduces their chance for visibility among government policies. They are deprived of the security and assistance which would otherwise be available for the male migrants. Hence there need to be studies that focus on the health of female migrants to help address their health concerns to integrate them with the state health policies.

Duration of Subject participation:
I will be asking some questions related to your social and demographic characteristics, related to self-reported morbidity patterns, health-seeking behaviour and healthcare utilization. This will take up to 30 minutes of your valuable time.

Risk or Discomforts:
Participation in the study does not impose any risk to health.

Benefits:
There is no direct benefit for you from this study but your valuable information will help in the benefits of the future migrant labourers who come to the city. This information will help in bringing out strategies that improve the health of the women Interstate migrant labourers.

Confidentiality:
Data Confidentiality will be maintained. Your identity will not be revealed to anyone. The information provided by you will not be shared with anyone not involved in the study. All the copies of filled interview schedules and consent forms will be kept under the custody of the principal investigator and will be destroyed when they are deemed no longer needed.

Voluntariness:
Your participation in the study is voluntary and you can withdraw from the study at any time and refusal to participate will not involve any form of penalty. If you have any questions about this study you may contact the people below.
Thanking you.

CONSENT STATEMENT

The nature of the study has been explained I confirm that I understood the information provided above. I am willing to take part in the above study by signing/providing a thumb impression on this consent form. I understand that my participation is voluntary and I can withdraw my participation at any time during the interview without any explanation.

Date:

Name of the Participant:

Signature / Thumb impression

Consent form for the interpreter (if needed)
I am willing to take part in the study by interpreting the language of the interview schedule.

Name:

Date:

Address:

Signature: